amount of allowable costs or the computation of the per diem rate of payment, shall be made within the first 90 days of the reporting year. The application shall specify:

(1) the nature of the change;

(2) the reason for the change;

(3) the effect of the change on the per diem rate of payment; and

(4) the likely effect of the change on future rates of payment.

(e) The Division shall review each application and within 60 days of the receipt of the application approve, deny, or propose modification of the requested change. If no action is taken within the specified period, the application will be deemed to have been approved. Hospital-based providers do not need to apply for approval of any change which has been approved by the Medicare fiscal intermediary, provided that documentation of such approval is submitted to the Division.

(f) Each provider shall notify the Division of changes in statistical allocations or record keeping required by the Medicare Intermediary.

(g) Preferred statistical methods of allocation are as follows:

(1) Nursing salaries and supplies - direct cost,

(2) Plant operations - square footage,

(3) Utilities - square footage,

(4) Laundry - pounds of laundry,

(5) Dietary -resident days,

(6) Administrative and General - accumulated costs,

(7) Property and Related: Depreciation of Equipment - specific identification,

(8) Property and Related: All other property costs - square footage,

(9) Fringe Benefits - direct allocation/gross salaries.

(h) Food costs included in allocated dietary costs are calculated by dividing the facility's allocated dietary costs by total organization dietary costs and multiplying by the total organization food costs.

(i) Utility costs included in allocated plant operation and maintenance costs are calculated by dividing the facility's plant operation and maintenance costs by total organization plant operation and maintenance cost and multiplying by the total organization utility costs.

(j) All administrative and general costs, including home office and management company costs, allocated to a facility shall be included in the Indirect Cost category.

(k) The capital component of goods or services purchased or allocated from a related or unrelated party, such as plant operation and maintenance, utilities, dietary, laundry, housekeeping, and all others, whether or not acquired from a related party, shall be considered as costs for that particular good or service and not classified as Property and Related costs of the nursing facility.

(l) Costs allocated to the nursing facility shall be reasonable, as determined by the Division pursuant to these rules.

### 2.4 Substance Over Form

The cost effect of transactions that have the effect of circumventing the intention of these rules may be adjusted by the Division on the principle that the substance of the transaction shall prevail over the form.

### 2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the uniform financial and statistical report (cost report), and must, upon request, make these records available to the Division of Rate Setting, or the U. S. Department of Health and Human Services, and the authorized representatives of both agencies.

(b) Complete documentation means clear and compelling evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service schedule and amounts of income received by service, or any other record which is necessary to provide the Director with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

(c) The provider shall maintain all such records for at least six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later. The Division shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting Summaries of Findings for six years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

(d) Pursuant to 33 V.S.A. §908(a), all documents and other materials filed with the Division are public information, except for individually identifiable health information protected by law or the policies, practices, and procedures of the Agency of Human Services. With the exception of the administrator's salary, the salaries and wages of individual employees shall not be made public.

## 3 FINANCIAL REPORTING

### 3.1 [Repealed]

### 3.2 Uniform Cost Reports

(a) Each long-term care facility participating in the Vermont Medicaid program shall annually submit a uniform financial and statistical report (cost report) on forms prescribed by the Division. The inclusive dates of the reporting year shall be the 12 month period of each provider's fiscal year, unless advance authorization to submit a report for a greater or lesser period has been granted by the Division.

(1) The Division may require providers to file special cost reports for periods other than a facility's fiscal year.

(2) The Division may require providers to file budget cost reports. Such cost reports may be used *inter alia* as the basis for new facilities' rates or for rate adjustments.

(b) The cost report must include the certification page signed by the owner, or its representative, if authorized in writing by the owner.

(c) The original and one copy of the cost report must be submitted to the Division. All documents must bear original signatures.

(d) The following supporting documentation is required to be submitted with the cost report:

(1) Audited financial statements (except that at the discretion of the Director, this requirement may be waived ),

(2) Most recently filed Medicare Cost Report with the required supplemental data on CMS Form 339 (if a participant in the Medicare Program), which for hospital-based nursing homes shall be the Medicare cost report for the same fiscal year as the Medicaid cost report,

(3) Reconciliation of the audited financial statements to the cost report.

(e) A provider must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information

which the Division requires in order to carry out its function.

(f) Providers shall follow the cost report instructions prescribed by the Director in completing the cost report. The chart of accounts prescribed by the Director, shall be used as a guideline providing the titles, and description for type of transactions recorded in each asset, liability, equity, income, and expense account.

3.3 **Adequacy and Timeliness of Filing**

(a) With the exception of hospital-based nursing homes, an acceptable cost report filing shall be made on or before the last day of the fifth month following the close of the period covered by the report.

(1) Hospital-based nursing homes shall file their Medicaid cost-reports within five days after filing their Medicare cost report for the same cost reporting period with CMS.

(2) If a hospital-based Medicaid nursing home's cost report is not filed on or before June 30 following the end of the facility's fiscal year, the Division may require the facility to provide certain data or to file a draft cost report.

(b) The Division may reject any filing which does not comply with these regulations and/or the cost reporting instructions. In such case, the report shall be deemed not filed, until refiled and in compliance.

(c) Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

(1) All Requests for Extension of Time to File Cost Report must be in writing, on a form prescribed by the Director, and must be received by the Division of Rate Setting 15 days prior to the due date. The provider must clearly explain the reason for the request and specify the date on which the Division will receive the report.

(2) Notwithstanding any previous practice, the Division will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director's sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial reason, one that affords a legal excuse for the delay or an intervening action beyond the provider's control. The following are *not* considered "good cause": ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

(d) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in subsection 3.3(a) or within an extension of time approved by the Division, shall be subject to the provisions of subsection 1.7(f).

3.4 **Review of Cost Reports by Division**

(a) Uniform Desk Review

(1) The Division shall perform a uniform desk review on each cost report submitted.

(2) The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review for the purpose of either settling the cost report without an on-site audit or determining the extent to which an on-site audit verification is required.

(3) Uniform desk reviews shall be completed within an average of 18 months after receipt of an acceptable cost report filing, except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.

(4) Unless the Division schedules an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

(b) On-site Audit

(1) The Division will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems in accordance with the relevant provisions of the *Medicare Intermediary Manual - Audits-Reimbursement Program*

*Administration*, CMS Publication 13-2 (CMS-13).

(2) The Division will base its selection of a facility for an on-site audit on factors such as length of time since last audit, changes in facility ownership, management, or organizational structure, evidence or official complaints of financial irregularities, questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

(3) The audit scope will be limited so as to avoid duplication of work performed by a independent public accountant, provided such work is adequate to meet the Division's audit requirements.

(4) Upon completion of an audit, the Division shall review its draft findings and adjustments with the provider and issue a written summary report of such findings.

(c) The procedure for issuing and reviewing Summaries of Findings is set out in Subsections 15.1, 15.2, 15.2 and 15.3.

### 3.5 Settlement of Cost Reports

(a) A cost report is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the Division has issued a final order pursuant to Subsection 15.3 of these rules.

(b) Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division's decision to reopen will be based on new and material evidence submitted by the provider, evidence of a clear and obvious material error, or a determination by the Secretary or a court of competent jurisdiction that the determination is inconsistent with applicable law, regulations and rulings, or general instructions.

(c) Reopening means an affirmative action taken by the Division to re-examine the correctness of a determination or decision otherwise final. Such action may be taken:

(1) On the initiative of appropriate authority within the applicable time period set out in paragraph (f), or

(2) In response to a written request of the provider or other relevant entity, filed with the Division within the applicable time period set out in subsection (f), and

(3) When the reopening has a material effect (more than one percent) on the provider's Medicaid rate payments.

(d) A correction is a revision (adjustment) in the Division's determination or Secretary's decision, otherwise final, which is made after a proper re-opening.

(e) A correction may be made by the Division, or the provider may be required to file an amended cost report. If the cost report is reopened by an order of the Secretary or a court of competent jurisdiction, the correction shall be made by the Division.

(f) A determination or decision may be reopened within three years from the date of the notice containing the Division's determination, or the date of a decision by the Secretary or a court.

(g) The Division may also require or allow an amended cost report to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, the provider is bound by its elections. The Division shall not accept an amended cost report to avail the provider of an option it did not originally elect.

## 4 DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

### 4.1 Provider Reimbursement Manual and GAAP

In determining the allowability or reasonableness of costs or treatment of any reimbursement issue, not addressed in these rules, the Division shall apply the appropriate provisions of the Medicare Provider Reimbursement Manual (CMS-15, formerly known as HCFA or HIM-15). If neither these regulations nor

CMS-15 specifically addresses a particular issue, the determination of allowability will be made in accordance with Generally Accepted Accounting Principles (GAAP). The Division reserves the right, consistent with applicable law, to determine the allowability and reasonableness of costs in any case not specifically covered in the sources referenced in this subsection.

4.2 **General Cost Principles**

For rate setting purposes, a cost must satisfy criteria, including, but not limited to, the following:

(a) The cost must be ordinary, reasonable, necessary, related to the care of residents, and actually incurred.

(b) The cost adheres to the prudent buyer principle.

(c) The cost is related to goods and/or services actually provided in the nursing facility.

4.3 **Non-Recurring Costs**

(a) Non-recurring costs shall include:

(1) any reasonable and resident-related per diem cost that exceeds one percent of the most recent certified overall per diem rate, which is not expected to recur on an annual basis in the ordinary operation of the facility, may be designated by the Division as a "Non-Recurring Cost" subject to any limits on the cost category into which the type of cost would otherwise be assigned,

(2) litigation expenses of $5,000 or more, recognized pursuant to subsection 4.20.

(3) allowable lump-sum recruitment and legal fees or similar expenses associated with the hiring of registered nurses from countries outside the United States on condition that such fees or expenses shall be allowable only in respect of such nurses who are paid at least the prevailing salary/wage and benefits for employed nurses of similar qualifications and experience in the geographic area in which the facility is located.

(b) A non-recurring cost shall be capitalized and amortized and carried as an on-going adjustment beginning with the first quarterly rate change after the settlement of the cost report for a period of three years.

4.4 **Interest Expense**

(a) Necessary and proper interest is an allowable cost.

(b) "Necessary requires that:

(1) The interest be incurred on a loan made to satisfy a financial need of the provider.

(2) A financial need does not exist if the provider has cash and/or cash equivalents of more than 60 days cash needs.

(3) Cash and cash equivalents include:

(i) monetary investments, including unrestricted grants and gifts,

(ii) non-monetary investments not related to resident care that can readily be converted to cash net of any related liability,

(iii) receivables from (net of any payables to) officers, owners, partners, parent organizations, brother/sister organizations, or other related parties, excluding education loans to employees.

(iv) receivables that result from transactions not related to resident care.

(4) Cash and cash equivalents exclude:

(i) funded depreciation recognized by the Division,

(ii) restricted grants and gifts.

(5) Interest income offset.

(i) Interest expense shall be reduced by realized investment income, except where such income is from:

(A)funded depreciation recognized by the Division pursuant to CMS-15,

(B) grants and gifts, whether restricted or unrestricted.

(ii) Only working capital interest expense shall be offset by interest income derived from working capital.

(6) The provider must have a legal obligation to pay the interest.

(c) "Proper" requires that:

(1) Interest be incurred at a rate not in excess of what a prudent buyer would have had to pay in the money market existing at the time the loan was made.

(2) Interest must be paid to a lender that is not a related party of the borrowing organization except as provided in paragraph (k).

(d) Interest expense shall be included in property costs if the interest is necessary and proper and if it is incurred as a result of financing the acquisition of fixed assets related to resident care.

(e) The date of such financing must be within 60 days of the date the asset is put in use, except for assets approved through the Certificate of Need process or approved by the Division under Subsection 4.11 of this rule. Allowable interest, on loans financed more than 60 days before or after the asset is put in use, will be included in Indirect Costs for the entire term of the loan.

(f) Borrowings to finance asset additions cannot exceed the sum of the basis of the asset(s), determined in accordance with Subsections 4.5 and 4.7, and other costs allowed pursuant to paragraph (g) related to the borrowing. The limit on borrowings related to fixed assets is determined as follows:

Basis of the assets recognized by the Division, plus a proportionate share of other costs allowed pursuant to paragraph (g), or

the principal amount of the loan, whichever is the lower:

Less: The provider's cash and cash equivalents in excess of 60 days needs, per subparagraph (b)(2) of this subsection.

Equals: The limits on borrowings related to fixed assets.

(g) Other costs related to the acquisition of the assets may be included in loans where the interest is recognized by the Division. These costs include bank finance charges, points and costs for legal and accounting fees, and discounts on debentures and letters of credit.

(h) Necessary and proper interest expense on debt incurred other than for the acquisition of assets shall be recognized as working capital interest expense and included in Indirect Costs.

(i) Application of Principal Payments.

(1) For loans entered into before a facility's 1998 fiscal year, principal payments shall be applied first to loan balances on allowable borrowings and second to non-allowable loan balances.

(2) For loans entered into during or after a facility's 1998 fiscal year, principal payments shall be applied to allowable and non-allowable loan balances on the ratio of each to the total amount of the loan.

(j) Refinancing of indebtedness.

(1) The provider must demonstrate to the Division that the costs of refinancing will be less than the allowable costs of the current financing.

(2) Costs of refinancing must include accounting fees, legal fees and debt acquisition costs related to the refinancing.

(3) Material interest expense related to the original loan's unpaid interest charges, to the extent that it is included in the refinanced loan's principal, shall not be allowed.

(4) A principal balance in excess of the sum of the principal balance of the previous

financing plus accounting fees, legal fees and debt acquisition costs shall be considered a working capital loan , subject to the cash needs test in subsection 4.4(b)(2), unless the provider demonstrates to the Division that the excess was for the acquisition of assets as set forth in (a) through (g).

(k) Interest expense incurred as a result of transactions with a related party (or related parties) will be recognized if the expense would otherwise be allowable and if the following conditions are met:

(1) The interest expense relates to a first and/or second mortgage or to assets leased from a related party where the costs to the related party are recognized in lieu of rent.

(2) The interest rate is no higher than the rate charged by lending institutions at the inception of the loan.

(l) Interest is not allowable with respect to any capital expenditure in property, plant and equipment related to resident care which requires approval, if the necessary approval has not been granted.

4.5 **Basis of Property, Plant and Equipment**

(a) The basis of a donated asset is the fair market value.

(b) The basis of other assets that are owned by a provider and used in providing resident care shall generally be the lower of cost or fair market value. Specific exceptions are addressed elsewhere in this rule. Cost includes:

(1) purchase price,

(2) sales tax,

(3) costs to prepare the asset for its intended use, such as, but not limited to, costs of shipping, handling, installation, architectural fees, consulting and legal fees.

(c) The basis of assets constructed by the provider to provide resident care shall be determined from the construction costs which include:

(1) all direct costs, including, but not limited to, salaries and wages, the related payroll taxes and fringe benefits, purchase price of materials, sales tax, costs of shipping, handling and installation, costs for permits, architectural fees, consulting fees and legal fees.

(2) indirect costs related to the construction of the asset.

(3) interest costs related to capital indebtedness used to finance the construction of the asset and prepare it for its intended use.

(d) The basis of betterments or improvements, if they extend the useful life of an asset two or more years or significantly increase the productivity of an asset are costs as set forth in paragraphs (b) and (c) above.

(e) Any asset or group of assets that has a basis of $1,000 or more and an estimated useful life of two or more years must be capitalized and depreciated in accordance with Subsection 4.6. Assets or groups of assets with a basis lower than $1,000 may be expensed or depreciated at the provider's election.

(f) The gain on a transfer of an asset to a related party shall be calculated as follows: the fair market value of the asset, less the net book value will be the gain irrespective of the of the amount paid to the facility for the asset. This gain will be offset against property and related costs.

4.6 **Depreciation and Amortization of Property, Plant and Equipment**

(a) Costs for depreciation and amortization must be based on property records sufficient in detail to identify specific assets.

(b) Depreciation and amortization must be computed on the straight-line method.

(c) The depreciable basis of an asset shall be the basis established according to Subsections 4.5 and 4.7, net of any salvage value.

(d) The estimated useful life of an asset shall be determined by the Division as follows:

(1) The recommended useful life is the number of years listed in the most recent edition of *Estimated Useful Lives of Depreciable Hospital Assets*, published by the American Hospital Association.

(2) Leasehold improvements may be amortized over the term of an arms-length lease, including renewal period, if such a lease term is shorter than the estimated useful life of the asset.

4.7 **Change in Ownership of Depreciable Assets - Sales of Facilities**

(a) A change of ownership will be recognized when the following criteria have been met:

(1) The change of ownership did not occur between related parties, except for transactions that meet the criteria in subparagraph (2).

(2) The transaction takes place between family members and meets the following conditions:

(i) The Division shall be notified at least two years before the sale. The notice shall include a description of the terms and conditions of the sale and be accompanied by a current appraisal of the facility being sold.

(ii) The buyer shall demonstrate the capacity to manage and/or administer the facility; or if the buyer is to be an absentee owner, the buyer shall demonstrate that there will be sufficient capable staff to operate the facility according to standards prescribed by state and federal law.

(iii) The seller shall not maintain full time employment with the facility, except for a transition period which shall not be longer than one year during which the seller may provide reasonable consultation to assure a smooth transition.

(iv) A sale of the facility shall not have occurred between any members of the same family within the previous 12 years.

(v) For the purposes of this subsection, family members shall include spouses, parents, grandparents, children, grandchildren, brothers, sisters, spouses of parents, grandparents, children, grandchildren, brothers and sisters, aunts, uncles, nieces and nephews, or such other familial relationships as the Director may reasonably approve in the circumstances of the transaction.

(3) The change of ownership was made for reasonable consideration.

(4) The change of ownership was a bona fide transfer of all the powers and indicia of ownership.

(5) The change in ownership is in substance the sale of the assets or stock of the facility and not a method of financing.

(i) If the transferor and the transferee enter into a financing agreement, the agreement must be constructed to effect a complete change of ownership. The Division shall determine if the agreement does in substance effect a complete change of ownership and the Division shall monitor the compliance with the agreement.

(ii) Where, subsequent to a change of ownership, the transferor forgives or reduces the debt of the transferee, the amount of the forgiveness or reduction shall be retroactively applied to the acquisition or basis of the asset as determined by the Division.

(6) The buyer shall demonstrate to the satisfaction of the Division that all obligations to the State of Vermont arising out of the transaction have been satisfied.

(7) For rate setting purposes, the transfer of stock or shares shall not be recognized as a change in ownership in the following circumstances:

(i) the transferred stock or shares are those of a publicly traded corporation.

(ii) the transfer was made solely as a method of financing (not as a method of

transferring management or control) and the number of shares transferred does not exceed 25 percent of the total number of shares in any one class of stock.

(b) Where the Division recognizes the change in ownership of an asset, the basis of the assets for the new owner shall be determined as follows:

(1) If the seller did not own the assets during the entire twelve year period immediately preceding the change in ownership or if the seller's facility did not receive Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred asset for the new owner shall be the lowest of:

(i) the fair market value of the assets,

(ii) the acquisition cost of the asset to the buyer,

(iii) the original basis of the asset to the seller as recognized by the Division, less accumulated depreciation.

(2) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred real property and fixed assets for the new owner shall be the lowest of:

(i) the fair market value of the assets,

(ii) the acquisition cost of the asset to the buyer,

(iii) the amount determined by the revaluation of the asset. An asset is revalued by increasing the original basis of the asset to the seller, as recognized by the Division, by an annual percentage rate. The annual percentage rate will be limited to the lower of:

(A) One-half the percentage increase in the Consumer Price Index (CPI) for All Urban consumers (United States City Average).

(B) One-half the percentage change in an appropriate construction cost index as determined by the Division of Rate Setting, which change shall not be greater than one-half of the percentage increase in the Dodge Construction index for the same period.

(3) After a change in ownership, the basis of moveable equipment and vehicles shall be the sellers net book value and shall be depreciated over a useful life of ten years.

4.8 [Repealed]

4.9 **Leasing Arrangements for Property, Plant and Equipment**

Leasing arrangements for property, plant and equipment must meet the following conditions:

(a) Rent expense on facilities and equipment leased from a related organization will be limited to the Medicaid allowable interest, depreciation, insurance and taxes incurred for the year under review, or the price of comparable services or facilities purchased elsewhere, whichever is lower.

(b) Rental or leasing charges, including sale and leaseback agreements for property, plant and equipment to be included in allowable costs cannot exceed the amount which the provider would have included in allowable costs had it purchased or retained legal title to the asset, such as interest on mortgage, taxes, insurance and depreciation.

4.10 **Funding of Depreciation**

(a) Funding of depreciation is not required, but it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with area-wide planning of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

(b) To the extent that the provider fails to retain sufficient working capital or sufficient resources to support operations, before making deposits in a funded depreciation account, the deposits will not be recognized as funded depreciation.

(c) To the extent that funded depreciation in the cost reporting period under consideration is used for purposes other than nursing facility asset acquisition, interest income on those sums will be offset against interest expense not only in the current period, but the Division may reopen settled cost reports for previous periods to revise funded depreciation and allowable interest expense. However, with the prior approval of the Division, under appropriate conditions, some or all of a provider's funded depreciation may be used as follows without triggering an interest income offset:

(1) to convert existing nursing home beds to residential care or assisted living, or

(2) when more economic, for new construction of residential care or assisted living units with a reduction in licensed nursing home beds.

(d) All relevant provisions of CMS-15 shall be followed, except as noted below:

(1) Replacement reserves. Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period expended, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest will apply.

(2) If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If the lessee is allowed to use this replacement reserve for the replacement of the lessee's assets, lessee shall not be allowed to depreciate the assets purchased.

(e) The provider must maintain appropriate documentation to support the funded depreciation account and income earned thereon to be eligible for relief from the investment income offset.

4.11 **Adjustments for Large Asset Acquisitions and Changes of Ownership**

(a) Large Asset Acquisitions

(1) A provider may apply to the Division for an adjustment to the property and related component of the rate for *individual* capital expenditures determined to be necessary and reasonable. No application for a rate adjustment should be made if the change to the rate would be smaller than one half of one percent of the facility's rate in effect at the time the application is made. Interest expense related to these assets, provided it is necessary and reasonable, shall be included in calculating the adjustment.

(2) In the event that approval is granted by the Division, the adjustment will be made effective from the first day of the month after the filing date of the written notice, following the date of the final order on the application, or following the date the asset is actually put into service, whichever is the latest.

(b) Changes of Ownership

(1) Application shall also be made under this subsection, no later than 30 days after the execution of a purchase and sale or other binding contract, for changes in basis resulting from a change in ownership of depreciable assets recognized by the Division pursuant to Subsection 4.7. The Division may make related adjustments to the Property and Related rate component.

(2) Adjustments to the Property and Related rate component resulting from a change in ownership of depreciable assets shall be effective from the first day of the month following the date of sale.

(c) Except in circumstances determined by the Division to constitute an emergency precluding a 60 day notice period, a provider applying for an adjustment pursuant to this subsection is required to give 60 days written notice to the Division prior to the purchase of the asset. Such applications shall be exempt from the materiality test set out in subsection 8.7(b), but are subject to the other provisions of subsection 8.7. The burden is on the provider to document all information applicable to this adjustment and to demonstrate that any costs to be incurred are necessary and reasonable. The Division shall review the application and issue draft findings approving, denying, or proposing modifications to the adjustment applied for within 60 days of receipt of all information required.

4.12 [Repealed]

4.13 **Advertising Expenses**

The reasonable and necessary expense of newspaper or other public media advertisement for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

4.14 **Barber and Beauty Service Costs**

The direct costs of barber and beauty services are not allowable for purposes of Medicaid reimbursement. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services are allowable.

4.15 **Bad Debt, Charity and Courtesy Allowances**

Bad debts, charity and courtesy allowances are deductions from revenues and are not to be included in allowable costs.

4.16 **Child Day Care**

Reasonable and necessary costs incurred for the provision of day care services to children of employees performing resident related functions will be allowable. Costs will be adjusted by any revenues received for the provision of care provided to employees' children. The direct and indirect expenses related to providing these services to non-employee children are not an allowable expense. Costs must be accumulated in a separate cost center. Revenues earned from providing day care must be identified for employees and non-employees in a separate account.

4.17 **Community Service Activities**

As an incentive for nursing home providers to furnish needed services (i.e., meals-on-wheels, adult day and certain respite care, etc.) to local communities, with the prior permission of the Division, only direct identifiable incremental costs will be adjusted (i.e., food, direct labor and fringe benefits, transportation). Overhead costs will not be apportioned for adjustment unless there is a significant expansion to a program resulting from community service involvement. The provider must maintain auditable records for all incremental direct costs associated with providing a community service.

4.18 **Dental Services**

Costs incurred for services performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth will not be allowed for the purposes of calculating the per diem rate. Dental services for Medicaid eligible individuals are covered pursuant to the *Vermont Welfare Assistance Manual.* However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services may be allowable.

4.19 **Legal Costs**

Necessary, ordinary, and reasonable legal fees incurred for resident-related activities will be allowable.

4.20 **Litigation and Settlement Costs**

(a) Civil and criminal litigation -

(1) General Rule. Attorney fees and other expenses incurred in conjunction with litigation will be recognized only to the extent that the costs are related to resident care, that the provider prevails, and that the costs are not covered by insurance.

(2) Settlements. In instances, where a matter is settled before judgment (whether or not a lawsuit has been commenced), one half the costs, including attorney fees, settlement award, and other expenses, relating to the matter will be recognized to the extent that the costs are related to resident care and are not covered by insurance.

(3) Costs related to criminal or professional practice matters are not allowable.

(b) Challenges to decisions of the Division - Attorney fees and other expenses incurred by a provider in challenging decisions of the Division will be allowed based on the extent to which the provider prevails as determined on the ratio of total dollars at issue in the case to the total dollars awarded to the provider.

(c) All costs recognized pursuant to this subsection shall be subject to the non-recurring costs provision in subsection 4.3(a)(2).

4.21 **Motor Vehicle Allowance**

Cost of operation of a motor vehicle necessary to meet the facility needs is an allowable cost. Where the vehicle is used for personal and business purposes, the portion of vehicle costs associated with personal use will not be allowed. If the provider does not document personal use and business use under a pre-approved method, DRS reserves the right to disallow all vehicle costs in question. All costs in excess of the cost of a similar size mid-price vehicle are not allowable.

4.22 **Non-Competition Agreement Costs**

Amounts paid to the seller of an on-going facility by the purchaser for an agreement not to compete are considered capital expenditures. The amortized costs for such agreements are not allowable.

4.23 **Compensation of Owners, Operators, or their Relatives**

(a) Facilities which have a full-time (40 hours per week minimum) administrator and/or assistant administrator, will not be allowed compensation for owners, operators, or their relatives who claim to provide some or all of the administrative functions required to operate the facility efficiently except in limited and special circumstances such as those listed in paragraph (b) of this subsection.

(b) The factors to be evaluated by the Division in determining the amount allowable for owner's compensation shall include, but not limited to the following:

(1) All applicable Medicare policies identified in CMS-15.

(2) The unduplicated functions actually performed, as described by the provider on the Medicaid cost report.

(3) The hours actually worked and the number of employees supervised, as reported on the cost report.

(c) The maximum allowable salary for an owner administrator shall be equal to 110 percent of the average of all reported administrator salaries for Vermont nursing facilities participating in the Medicaid program as increased to the current cost reporting period by the wages and salaries portion of the Health-Care Cost Review .

4.24 **Management Fees and Home Office Costs**

(a) Management fees, home office costs and other costs incurred by a nursing facility for similar services provided by other entities shall be included in the Indirect Cost category. These costs are subject to the provisions for allowable costs, allocation of costs and related party transactions contained in these rules and shall include property and related costs incurred for the management company. These costs are allowable only if such costs would be allowable if a nursing facility provided the services for itself.

(b) Allowable costs shall be limited to five percent of the total net allowable costs less reported management fees, home office, or other costs, as defined in this subsection.

4.25 **Membership Dues**

Reasonable and necessary membership dues, including any portions used for lobbying activities, shall be considered Medicaid allow-